UTAH PUBLIC MENTAL HEALTH SYSTEM PREFERRED PRACTICE GUIDELINES

HOUSING/IN HOME SKILLS AND CASE MANAGEMENT FOR ADULTS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS

DECEMBER 1998

Utah Public Mental Health System
Preferred Practice Guidelines

Table of Contents

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Utah Public Mental Health System
Preferred Practice Guidelines
Housing/In Home Skills
for People with Serious and Persistent Mental Illness

GOAL
To define and provide uniform and consistent preferred practice guidelines for Housing Programs for people with mental illness provided by the community mental health centers in the State of Utah.

STATEMENT OF INTENT
These practice guidelines are not to be construed to limit in any way the individualization of treatment, clinician creativity, or the ability of the clinician to provide treatment in the best interests of the client. Guidelines are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve. These guidelines for practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care, or excluding other acceptable methods of care aimed at the same results. It is recognized that optimal outcomes will not always be obtained in treatment. Finally, these guidelines are not meant to obligate a mental health treatment center to provide housing to every client, or to diminish the client's individual right and responsibility to secure their own housing.

OPTIMAL OUTCOME
The Preferred Practice Guidelines summarized below should guide the work of the community mental health centers (CMHCs) in providing assistance to individuals with psychiatric disabilities and their families. These guidelines are based on the central belief that recovery is possible and is the core goal of services and supports. Combining an expectation of hope for recovery within best practices should characterize all efforts to reintegrate individuals with psychiatric disabilities into our communities.

PREFERRED PRACTICE GUIDELINES:

1. Each CMHC should be sensitive to the housing needs of its clients by listening to and communicating with mental health clients, advocates and service providers and regularly assessing the housing needs and options.

2. Identified preferred practices include: Supported Housing, Supported Education, Assertive Community Treatment and other models of Case Management, Psychosocial Rehabilitation, Peer Support and Self-help.

PREFERRED PRACTICES (continued):

3. CMHCs should provide designated staff, and train other staff, to assist and support clients in obtaining affordable housing[1], defined as an individual contribution of no more than 30% of household income, and that there are not adverse health or safety issues.

4. Each CMHC should seek to separate housing/in home skill issues from clinical issues. This may take the form a Residential Agreement (for treatment-based housing) or the use of a standard lease agreement (for supported housing).

5. Each CMHC should have referral, admission, and discharge criteria for each of the housing programs they own, manage, supervise, lease, or sublease. Criteria should acknowledge opportunities to maintain housing, and opportunities to transition to housing options that have more independence.

6. Mental health services in housing programs should include services that are planned with full involvement of clients and may include Residential Groups/Councils. Client choice of services may only be negated in the event of civil commitment.

7. Mental health services in housing programs should be focused on recovery as defined by self-sufficiency and adaptive functioning.
    A. Clients are assessed regularly for psychosocial rehabilitation, strengths and needs.
    B. Frequent re-evaluation of clients' strengths and weaknesses and potential for independence

8. Mental health services in housing programs should be flexible, so as to meet client needs. CMHCs should educate clients and/or provide staff to assist with a variety of permanent and/or transitional housing options. Mental Health Housing Programs admission should generally be guided by client's choice, pending CMHC's admission criteria.

9. Mental health services in housing programs should incorporate measurable outcomes that are relevant to people's personal goals, clinical goals, and quality of live, and should be routinely evaluated by clients, service providers, and funders for their effectiveness and user friendliness, and include a systems-wide commitment to learning, adaptation, and improvement.

[1] Definition of Safe and Affordable Housing: 30% of the individual or family income with no adverse health or safety issues. The percentage of individual or household income can vary depending on the client's income and the CMHC's internal policy and resources.

PREFERRED PRACTICES (continued):

10. Mental Health Services in Housing Programs should be provided by a competent and diverse work force (within treatment-based housing, the program staff may include people with and without a history of psychiatric disability) with specific attitudinal, knowledge, and skill competencies, and with sensitivity to the race, ethnicity, age, economic status, gender and sexual orientation of those they serve.

11. People with psychiatric disabilities have the same rights and responsibilities as all other citizens. Legal protections and tools should be utilized, such as those found in the Fair Housing Amendments Act, Section 504 of the Rehabilitation Services Act, and should be in compliance with state statues and regulations and well as local zoning ordinances, including provision of the Americans with Disabilities Act, and grievance procedures with both treatment-based housing and supported housing systems. These are important tools for assisting people with psychiatric disabilities in meeting their housing needs. A statement of fair housing and client rights should be stated in the agreement of services

Utah Public Mental Health System
Housing Plan/In Home Skills
for People with Serious and Persistent Mental Illness

VALUE:
Shelter is a basic human need. Appropriate housing options provide the stability for a person's well being. Housing programs for people with mental illness must be safe and affordable. The community mental health center's housing programs for people with psychiatric disabilities is responsible for assisting the client in developing the skills necessary in maintaining, and transitioning to, independent circumstances with minimal disruption. The mental health services may include the following services: individual therapy, group therapy, behavioral management, case management, medication management, and psychosocial and educational approaches to teach self-management and maintenance of the living environment.

DEFINITIONS
Supported Housing and mental health services should be viewed as separate needs and should not be bundled together. Rather, they should be provided in partnership with each other. Services should be organized and staffed to provide general and specialized interdisciplinary services with crisis services available 24 hours per day, seven days per week. It is vital to separate landlord and property management functions from the service delivery roles. Housing planning should be closely linked to the supports that people need for recovery. Mental health clients should have a central role in the planning process. The target population for this intensive service is individuals with a high level of need for both housing assistance and support services.

Treatment-based Housing and mental health services are not separate needs and should be organized and staffed to provide general and specialized interdisciplinary services with crisis services available 24 hours per day, seven days per week. Services may be provided onsite, in freestanding facilities, or in units of larger entities. Termination of services is based on the same conditions of treatment as with the community mental health center. Planning for treatment-based housing should be closely linked to planning for the supports that people need for recovery. In addition, people with psychiatric disabilities should have a central role in the planning process. The target population for treatment-based housing should encompass all levels of need.

SCOPE OF CARE
A range of treatment, support, skill development, and case management services are provided to help clients to be successful in achieving the skills to manage the living environment or arrangement of their choice. Services must be individualized, depending on the client's needs and desires. Client choice may be only negated in the event of civil commitment. The goal of such service delivery should involve clients in planning for services that enhances client dignity, self-worth, and self-sufficiency.

POLICY

Community mental health centers that participate in housing persons with psychiatric disabilities will be consistent with this Housing Plan and the Preferred Practice Guidelines. State and community mental health systems have a responsibility to focus on housing needs as a necessary and integral component of recovery and community support.

Housing planning should: 1) focus on permanent housing that is affordable, defined as an individual contribution of no more than 30% of household income, and that there are no adverse health or safety issues, 2) be based on the preferences and choices of people with psychiatric disabilities, and 3) provide options for full integration with people who are not disabled.

Each CMHC should be sensitive to the housing needs of its clients by listening to and communicating with its mental health clients, advocates and services providers, and should regularly assess the housing needs and options. For those people with mental illness who require support to live in the least restrictive setting, mental health services will be offered in conjunction with housing. These support services may include a case manager and/or housing specialist, and services would emphasize independent living skills to help clients meet their own needs.

Housing programs developed will encourage healthy lifestyles without substance abuse. Support services should be available for persons who substance use may interfere with their ability to maintain housing stability.

Unfortunately, clients sometimes lose their housing when temporarily in need of hospitalization or out of home treatment. When possible, appropriate arrangements should be made to secure housing options and assist clients in maintaining their housing while hospitalized.

Housing/In Home Skills Programs should be integrated throughout the community and within a range of services from high contact (the least independent) to low contact (the most independent). The programs, including apartments leased by the CMHC for independent living, are mental health programs, and clients who enter into a contract with the individual CMHC treatment-based housing programs are considered clients of mental health systems upon which admission and discharge criteria are based. The housing programs may provide an opportunity for transitional and/or permanent housing, depending on the community mental health center's housing program criteria, resources and the clinical needs of the client.

CMHCs' supported housing programs differ from treatment-based housing in that mental health support services and housing are separate needs and should not be regarded as mental health treatment. With supported housing, there should be no mental health treatment requirements for obtaining or maintaining housing. Termination of tenancy by the independent landlord must be based on the same conditions of tenancy that apply to non-disabled tenants.

	TREATMENT-BASED HOUSING			SUPPORTED HOUSING
	Level I High Contact	**Level II Moderate Contact**	**Level III Low Contact**	**All Levels for Supported Housing**
Definition	24-hour housing programs structured treatment regimen. Range of contacts should include at least one contact per day at place of residence.	Range of contacts, not necessarily at place of residence, should be two to five per week. Minimum contact at residence should be at least one time weekly.	Range of contacts; client is seen once a week, not necessarily at their residence. Minimum contact on time per month at residence.	Supported housing and mental health services should be viewed as separate needs and should not be "bundled" together. Rather, they should be provided in partnership with each other. Services should be organized and staffed to provide general and specialized interdisciplinary services with crisis services available 24 hours per day, seven days per week. It is vital to separate landlord and property management functions from the service delivery roles. Housing planning should be closely linked to the supports that people need for recovery. Mental health clients should have a central role in the planning process
Admission	Diagnosis: Meets state criteria for serious and persistent mental illness (SPMI). Persons with SPMI are priority. Symptoms are disabling and persistent. Severity: Recently extended or repeated hospitalizations or crisis episodes. Symptoms interfere with life in a highly disabling manner. Assessment: Scale ratings will show severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of illness. Currently receiving mental health services with the CMHC. The client agrees to participate in mental health services and, if needed, substance abuse treatment. Required to have income or related entitlement, i.e. SSI, Medicaid, private insurance. Unfunded clients follow CMHC's internal policy. Clients' medical needs are appropriate to the capacity of staffing and/or facility.	Diagnosis: Meets state criteria for serious and persistent mental illness (SPMI). Persons with SPMI are priority. Symptoms are disabling and persistent. Severity: Past hospitalizations, but no recent major crisis activity or hospitalization. Assessment: Scale ratings will show skill and resource deficits that impair the person's ability to achieve personal goals, and community living. Currently receiving mental health services with the CMHC. The client agrees to participate in mental health services and, if needed, substance abuse treatment. Required to have income or related entitlement, i.e. SSI, Medicaid, private insurance. Unfunded clients follow CMHC's internal policy. Clients' medical needs are appropriate to the capacity of staffing and/or facility.	Diagnosis: Meets state criteria for serious and persistent mental illness (SPMI). Persons with SPMI are priority. Symptoms are minimal and enable community living and rehabilitation efforts. Severity: Extended period with no hospitalizations or major crisis episodes. Largely self-manages disability and medication; able to manage own progress with occasional assistance or coordination Assessment: Scale ratings will show moderate to mild dysfunction. Currently receiving mental health services with the CMHC. The client agrees to participate in mental health services and, if needed, substance abuse treatment. Required to have income or related entitlement, i.e. SSI, Medicaid, private insurance. Unfunded clients follow CMHC's internal policy. Clients' medical needs are appropriate to the capacity of staffing and/or facility.	

	TREATMENT-BASED HOUSING			SUPPORTED HOUSING
	Level I High Contact	**Level II Moderate Contact**	**Level III Low Contact**	**All Levels for Supported Housing**
Focus/ Activities	Focuses on learning basic independent living skills, i.e., grooming, hygiene, and ability to ask for help. Decreasing symptoms and side effects of medication, and willingness to follow through with medication management, and increasing periods of independence, building support networks, and minimizing or eliminating periods of crisis or severe dysfunction. Establish sense of self and personal aspirations.	Focuses on learning intermediated independent living skills and obtaining recovery outcomes through maximizing strengths, i.e., apartment maintenance, shopping, money management, learning how to secure entitlements and keep them current, medication management, ability to recognize symptoms with partial supervision and learn about illness; developing community supports and resources to meet objectives of independent living,	Focuses on maintaining housing stability and independence with ability to provide own day structure with links to community services; psychiatric/medication services and skills to seek crisis prevention and intervention; shopping skills; medication management; ability to complete SSI and Medicaid reviews; training for money management; skills employment and/or day structure with little or no assistance.	Services and supports must include wrap around mental health services. Successful programs may use a team structure that includes case coordination activities, in-home rehabilitation services, and assistance in locating and moving into regular, integrated housing. Continued residency in housing may not be made contingent on compliance with treatment.
Caseload	Recommended average of ten persons per staff, depending on needs of persons served and teams availability (the range could be from 5 to 15 persons per staff except in rural areas), practiced in teams or 24-hour crisis coverage and mutual support. Best Practice: Team support that should include one full time nurse, part time psychiatrist, a housing specialist or case manager that works with housing issues, a representative payee if needed, and clinicians on the team. Face-to-face assessment of needs at place of residence should be available 24 hours a day, seven days per week.	Recommended average of 20 persons per staff, depending on needs of persons served and teams availability (the range could be from 10 to 25 per staff persons except in rural areas). Caseloads are individual or team, with 24-hour crisis coverage and mutual support. Best Practice: A psychiatrist and nurse, job specialist, housing specialist, a representative payee if needed, and clinicians on the team. Face-to-face assessment of needs at place of residence should be at least four times per month.	Recommended average of 30 persons per staff, depending on needs of persons served and team availability (the range could be from 25 to 50 persons per staff). Usually, individual practice with some team features; collaborates with medication service. Available for crisis prevention/intervention 40 hours per week with back up arrangements at other times. Face-to-face assessment of needs at least one time per month.	Range: no average. The recommended staff average of 13 persons per staff, depending on the range of services in the community and the needs of persons served, and team availability. Caseload range should be dynamic with caseloads shifting with client acuity on the needs of the client. Range of contacts to client ratio is not more than 1 to 15 (direct care staff; this does not include administrative staff). Best Practice: Team support; should include one housing specialist or case manager with housing knowledge, job specialist, and a representative payee if needed. Team does not necessarily need to be under one supervisor or located at one site. Face-to-face assessment of needs at place of residence should be available 24 hours a day, seven days a week, depending on the needs of the client, with 24-hour crisis coverage seven days per week.

	TREATMENT-BASED HOUSING			SUPPORTED HOUSING
	Level I High Contact	**Level II Moderate Contact**	**Level III Low Contact**	**All Levels for Supported Housing**
Discharge (Treatment-based housing is defined as a treatment service, not as an obligation of the CMHC) Each program will insure that a discharge planning process for each client begins upon admission.	Generally, client's choice with the involvement of the program staff and clinical assessment of the psychiatric status and the client's rehabilitation needs and goals. Increased community support and housing stability with reductions in the frequency or length of crisis or hospital services. Also, decrease in symptoms and side effects; increased social integration, reduced impairment from substance abuse and decrease in level of care required. Client satisfaction. Can perform basic skills, i.e., hygiene, ability to follow through with daily activities, basic awareness of symptoms, basic apartment maintenance skills with assistance, compliance with medication management. Discharge may also be immediate if the client poses a substantial threat to the health, safety, and well being to self or others, or creates a serious and ongoing disruption of the environment of the program. Discharge will usually be to Level II Moderate Contact housing, if available. Client choice may be negated when it is necessary.	Generally, client's choice with the involvement of the program staff and clinical assessment of the psychiatric status and the client's rehabilitation, physical, social and residential needs and goals. Increased community support and housing stability with decreased crisis episodes; increase in time spent working or going to school; increase in social contacts; increase in personal satisfaction and independence. Achievement of independence or semi-independent living arrangement. Reduced impairment from substance abuse. Client satisfaction. Performs intermediate independent living skills, i.e., cooking, money management, laundry, ability to use public transportation, medication management. Understands symptoms. Involvement with daily activities with moderate assistance. Discharge may also be immediate if the client poses a substantial threat to the health, safety, and well being to self or others, or creates a serious and ongoing disruption of the environment of the program. Discharge will usually be to Level II Moderate Contact housing, if available, or other resources.	Generally, client's choice with the involvement of the program staff and clinical assessment of the psychiatric status and the client's rehabilitation, physical, social and residential needs and goals. Satisfaction with personal life domains and continued housing stability as measured by few or no hospitalizations and a continued decrease in frequency and duration of crisis episodes. Increased personal independence. Sustained recovery from substance abuse. Improved independent living skills in the community with additional supports, family, friends, job. Client satisfaction. Can perform advanced independent living skills, i.e., cooking, laundry, transportation, shopping skills, daily activities with no assistance, successful history of medication management with minimum assistance, money management skills. Client is able to meet treatment goals, has community supports, and housing services. Discharge may be immediate if the client poses a substantial threat to the health, safety, and well being of self or others or creates a serious and ongoing disruption of the environment of the program. Discharge will usually be to the community.	Client's choice, with appropriate involvement of the program staff, and with clinical assessment, as needed, of the psychiatric status as well as the client's rehabilitation, physical, social and residential needs, goals and potentials.

Utah Public Mental Health System
Preferred Practice Guidelines
Case Management
for Adults with Serious and Persistent Mental Illness

GOAL
To define and provide uniform and consistent preferred practice guidelines for Case Management Programs serving people with mental illness in community mental health centers (CMHCs) in Utah.

STATEMENT OF INTENT
These practice guidelines should not be misconstrued as an attempt to limit the individualization of services, clinical creativity, or the ability of the mental health staff to provide services in the best interest of the client. Guidelines are determined on the basis of all the data available and are subject to change as scientific knowledge and technology advance and patterns evolve. With this in mind, the following information should be considered only as guidelines, not as standards. Adherence to them will not ensure a successful outcome in every case, nor should they be misread as including all the proper methods of care or excluding other acceptable methods of care aimed at the same results. It is recognized that optimal outcomes will not always be obtained.

SERVICE DESCRIPTION
Case Management is a form of support that assists persons with serious mental illness to optimize their adjustment in the community. In case management, one person, or a team of providers, assumes the management of the care of a person with a serious mental illness. Case Management is usually done in the community as opposed to an office type setting and may be done in the client's home, place of employment, shelter, on the streets, in residential settings, etc. The frequency of contact between the case manager and the client is typically higher than the frequency of contact in a customary outpatient setting. The case managers provide continuity of care for the client in the mental health system and address not only the manifest symptoms of the illness but also may address psychosocial problems such as housing, transportation, application and attainment of entitlements, attainment of food, activities of daily living (ADLs), medical appointments, education, employment, and other activities.

OPTIMAL OUTCOME
The Preferred Practice Guidelines summarized below guide the work of the CMHCs, providing assistance to individuals with psychiatric disabilities. These guidelines are based on the central belief that recovery is possible and is the core goal of services and supports. Combining an expectation and hope for recovery with best practices should characterize all efforts to effectively reintegrate individuals with psychiatric disabilities into our communities.

PREFERRED PRACTICE GUIDELINES

1. Client centered: Services are responsive to the needs of the client rather than the needs of the system or the providers. The majority of services should be delivered in the client's natural setting.

2. Client empowering: Services incorporate client self-help approaches and are provided in a manner allowing clients to retain the greatest possible control over their own lives. As much as possible, clients set their own goals, decide what services they will receive and are active participants in the Service Plan and services provided. This principle allows the client to share in the recovery process to the greatest possible extent.

3. Racially and culturally appropriate: Services should be available, accessible, and acceptable, when possible, to all the clients it serves regardless of race, religion, sex, sexual preference, or physical ability.

4. Focused on strengths: Services build upon the assets, strengths, and capacities of clients in order to help them maintain a sense of identity, dignity and self-esteem. Services goals should be solution oriented and achievable.

5. Normalized and incorporated natural supports: Services are offered in the least restrictive, most natural setting possible. Clients are encouraged to use the community and to experience integration into normal living, working, learning, and leisure time activities.

6. Special Needs: Services should be adapted, or resources accessed, to meet the needs of subgroups of persons with serious mental illness, such as elderly individuals in the community or in institutions; young adults, individuals with mental illness and substance abuse problems, development disabilities, or hearing impairments; persons with mental illness who are also homeless; and persons with mental illness who are inappropriately placed within the criminal justice system, as resources allow.

7. Outcomes: Service systems and providers should be accountable to the users and the payors of the services. Services should be monitored to assure quality of care and continued relevance to client needs. Clients and families (with client's consent) should be involved in planning, implementing, monitoring and evaluating services. This principle includes explicit reference to client satisfaction, client outcomes, and stewardship of public funding.

Utah Public Mental Health System
Adult Case Management Plan
for People with Serious and Persistent Mental Illness

STATE OF UTAH DEFINITION OF CASE MANAGEMENT (DSAMH)

Case management is a process in which the client is a partner, to the greatest extent possible, in assessing needs, obtaining services, treatments and supports, and in preventing and managing crisis. The focus of the partnership is recovery and self-management of mental illness and life. The client and the case manager coordinate, advocate, link and monitor for services and supports directed toward the achievement of the individuals' personal goals for community living. Certified case managers include:

1. Licensed mental health professionals, including licensed physicians, licensed psychologists, licensed certified or clinical social workers, licensed social service workers, licensed registered nurses, licensed marriage and family therapists, or licensed professional counselors;

---Or---

2. Licensed practical nurses or non-licensed individuals who have met the State Division of Substance Abuse and Mental Health's training standards for case managers, and who are supervised by one of the licensed mental health professionals identified in number (1) one.

SCOPE OF SERVICES (AS APPROVED AND DEFINED BY STATE MEDICAID)

(Provider qualifications vary amongst the different services)

1. Targeted Case Management:
   (TCM also includes Team CM and Short-term CM; CM notates Case Management not the Case Manager) CM is a service that assists eligible clients in the target group to gain access to needed medical, social, education, housing and other services. The overall goal of CM is to help Medicaid recipients access needed services, and to ensure that services are coordinated between all agencies and providers involved. The purpose of gaining access to services and service coordination is to assist clients to reach their goals and/or assist clients in the recovery process with improved community integration and gain the abilities to self-manage to the greatest degree possible.
2. Clinical Services:
   Skills Development Services (SDS) may be provided by: a certified Case Manager, or Mental Health staff under the supervision of a licensed provider including SSW's, LCSW's, and RN's.
   SDS means rehabilitative services designed to: 1) assist individuals to develop competence in basic living skills such as food planning, shopping, food preparation, money management, mobility, grooming, personal hygiene, maintenance of the living environment, and appropriate compliance with the medication regimen, 2) teach individuals to develop awareness of community resources, and 3) teach individuals to develop social skills including communication and socialization skills and techniques. Symptom management and/or skill development services may also include supportive counseling directed toward eliminating psychosocial barriers that impede the individual's ability to function successfully in the community. Services must be authorized and provided in accordance with the Utah Mental Health Practice Act.

3. Behavioral Management: Behavior management means face-to-face interventions with an individual or group of individuals experiencing a specific behavioral problem using a psycho-educational approach, after diagnosis by a mental health therapist, and in accordance with a treatment

plan developed, directed, and supervised by the mental health therapist, and includes stress management, relaxation techniques, assertiveness training, conflict resolution, and behavior modification. Groups should not exceed 10 individuals unless a co-leader is present.
May be provided by: licensed mental health therapist; an individual not currently licensed but enrolled in a program leading to qualifying for licensure, or engaged in completion of clinical training after completion of the education, working under the supervision of a licensed mental health therapist; licensed registered nurse; licensed social service worker working under the supervision of a licensed mental health therapist; student enrolled in a program leading to licensure as a certified social worker working under the supervision of a licensed mental health therapist or a licensed certified social worker; student enrolled in a program leading to licensure as a registered nurse, working under the supervision of a licensed registered nurse; student enrolled in a program leading to licensure as a social service worker, working under the supervision of a licensed mental health therapist.

ASSESSMENT CRITERIA: Any client of the mental health system may be referred for assessment for CM services. The following factors will be assessed:

1. Client voluntary choice.

2. There is a diagnosable Axis I Diagnostic and Statistical Manual IV (DSM-IV) psychiatric disorder. Axis II psychiatric disorders also qualify if there are sufficient functional difficulties, an extended duration of problems/illness, and continued reliance upon public services and supports.

3. The treatment/service must be clinically necessary: 1) there is significant functional impairment, 2) there are psychosocial needs, 3) acuity level.

4. There is reasonable expectation that the CM intervention/support will reduce and stabilize symptoms, improve behaviors, and increase the potential for recovery.

5. Discharge from the Utah State Hospital.

6. Currently meets State SPMI definition[2].

[2] Utah SPMI definition see Appendix I, page 20. For the federal definition of SPMI, see Federal Register, Vol. 58, No. 96 (May 20, 1993).

DETERMINING THE LEVEL OF INTENSITY OF CASE MANAGEMENT

The level of CM Services will be determined by a formal needs assessment that may include clinical acuity as well as the following factors:

Client requests, preferences or right of refusal must be a primary factor in the assignment decision, especially if CM services are available at more than one site. Once there is agreement about the assignment to CM, there is a continuing need for sensitivity to the client's voluntary choice about the intensity of services.

Willingness is closely associated with client choice. Persons may be temporarily satisfied with their lives and circumstances, not desiring to begin work on more progressive goals and objectives. Willingness must be cautiously evaluated by case managers and must not be used an "excuse" for under serving. It is important to note that case managers can positively influence willingness by fostering hope and belief in the person receiving services.

Social resources and natural supports available to clients will affect decisions about the intensity of CM. Care must always be taken to respect interest of the family and client, not to make the family the de facto case manager. The availability of client self-help opportunities and other human/social services will also affect the level of CM required.

Safety should play a role in the CM assignment decision. People who are vulnerable to violence or abuse, or who are themselves prone to violent or abusive behaviors, may require a more intensive level of treatment. Clients who are a safety risk should be assessed for more intensive services.

Culture is also a critical determinate for CM. All case managers must be aware of the ethnicity and heritage of the people they serve. Specific training in Cultural Competency and sensitivity is encouraged for all case managers.

Co-occurring conditions or situations will also affect assignment. Case managers who are working with people who have a dual diagnosis should seek additional training, and/or when possible refer to an individual who specializes in areas such as: substance abuse, other dual diagnosis, mentally ill people who are elderly, physically or developmentally disabled or involved with the forensic system.

Legal issues may be a factor in the selection of CM intensity. Persons with guardians or persons who are involuntarily committed may also be assigned a particular level or CM intensity. Persons on parole or who have continuing involvement with the forensic system may require special consideration and/or coordination with those systems.

DISCHARGE CRITERIA: Continuation of CM will be related to needs, choices, and behavioral health status. Discharge criteria from CM may be based upon any of the following:

1. Client voluntary choice.
2. Achievement of a significant degree of independence
3. Achievement of a significant clinical improvement (pending completion of goals)
4. Significant improvement in self management skills
5. Having found alternate community support
6. Significant goal attainment

DESCRIPTION OF THE THREE LEVELS OF CASE MANAGEMENT
(Case Management Services allows for Blended Caseloads of Level I, II, and III)

	Level I CM	**Level II CM**	**Level III CM**
Description	Level I CM is the most intensive level of CM. Through frequent, comprehensive CM, support is give to most severely disabled adults. Crisis coverage is accessible 24 hours per day, seven days per week. (Crisis services may be provided by other MH providers.)	Level II CM provides a moderate level of CM support to the adult population in which symptoms are at least partially controlled. CM is goal-directed, recovery and outcome-oriented for people who wish to make regular progress in growth and rehabilitation. Crisis coverage is accessible 24 hours per day, seven days per week. (Crisis services may be provided by other MH providers.)	Level III CM is the least intensive CM mode provided to people who are somewhat satisfied with their life situation, or are largely able to self-manage much of their progress. Services are provided pending the client's needs with on-call crisis intervention, or other crisis intervention arrangements.
Admission	Diagnosis: Meets State criteria for serious and persistent mental illness. Symptoms are disabling and persistent. Severity: Past hospitalizations, but no recent major crisis activity or hospitalization. Assessment: Will show severe deficits in skills and resources needed for community living.	Diagnosis: Meets State criteria for serious and persistent mental illness. Symptoms are partially controlled, thereby enabling rehabilitation efforts. Severity: Past hospitalizations, but no recent major crisis activity or hospitalization. Assessment: Will show skill and resource deficits which impair the person's ability to achieve personal goals independently.	Diagnosis: Meets State criteria for serious and persistent mental illness. Severity: Extended period with no hospitalizations or major crisis episodes. Largely able to independently manage symptoms and medication. Some satisfaction with current life and able to make significant progress towards goals with occasional assistance. Assessment: Will show moderate dysfunction.

DESCRIPTION OF THE THREE LEVELS OF CASE MANAGEMENT

	Level I CM	**Level II CM**	**Level III CM**
Focus/Activities	Focuses on obtaining basic human needs and supports; decreasing symptoms and side effects of medication; increasing periods of independence; building support networks; minimizing or eliminating periods of crisis or severe dysfunction. Teaches and models positive behaviors and helps people re-establish sense of self and personal aspirations.	Focuses on obtaining recovery outcomes and maximizing strengths; developing, implementing, and coordinating a client centered comprehensive service plan. Obtains and coordinates services and resources to meet objectives of the service plan; teach skills. Provides consistent direct service support.	Focuses on maintaining stability and independence by providing a link to services and interface with psychiatric and medication services, crisis prevention and intervention. Client is able to have a direct point of contact to mental health system, with emphasis on coordination and linking.
Caseload/Mode	Recommended average of 13 persons per case manager. Depending on the needs of persons served and team availability, the range could be from 5 to 15 persons per caseload except in rural areas, due to transportation limitations. Active teams (24-hour coverage) and mutual support caseloads may be assigned to individual case managers or teams as a whole. Best Practice includes one full or part-time nurse and part-time psychiatrist, or a physician with special mental health training in rural areas, job specialist and housing specialist on the team. Face-to-face assessment of needs two to four times per week with at least one contact at place of residence.	Recommended average of 24 persons per caseload. Depending on the needs of persons served and team availability, the range could be from 15 to 30 persons per case manager, except in rural areas. Caseloads are individual/team. Best Practices: psychiatrist and nurse, job specialist and housing specialist on the team. Face-to-face assessment of needs at least four times per month with one contact at place of residence, based on individual need.	Recommended average of 50 persons per caseload. Depending on the needs of persons served and team availability, the range could be from 30 to 80 persons per case manager. Usually, individual practice in office with some team features. Collaborates with medication service. Available crisis prevention/ intervention Monday through Friday, 8:00 a.m. to 5:00 p.m., with back up arrangements at other times. Face-to-face assessment of needs at least one time every 90 days at place of residence. Two face-to-face and eight telephone contacts per year.

DESCRIPTION OF THE THREE LEVELS OF CASE MANAGEMENT

	Level I CM	**Level II CM**	**Level III CM**
Internal Review of Services	Initial authorization: One year, reauthorization in 90-day intervals. Continued stay based on degree of symptoms and crisis reduction and/or positive response to treatment.	Initial authorization: One year, reauthorization in 90-day intervals. Continued stay based on progress with rehabilitation goals and desire for further recovery progress.	Initial authorization: 90 days in one year, and every year thereafter as person chooses to have continued CM linkage to mental health systems.
Expected Outcomes	Increased community tenure and reductions in the frequency or length of crisis or hospital services. Also, increased housing stability; decrease in symptoms and medication side effects; increased social integration; reduced impairment from substance abuse; and decrease in level of care needed or desired. Client satisfaction; achievement of independence or semi-independent living arrangement.	Increased community tenure; decreased crisis episodes, increase in time spent working or in school; increase in social contacts; increase in personal satisfaction and independence. Achievement of independence or semi-independent living arrangement. Reduced impairment from substance abuse. Client satisfaction.	Increased client satisfaction with personal life domains and continued stability as measured by rare, brief, hospitalizations and a continued decrease in frequency and duration of crisis episodes. Increased personal independence in any life domain. Sustained recovery from substance abuse.

DESCRIPTION OF THE THREE LEVELS OF CASE MANAGEMENT

	Level I CM	**Level II CM**	**Level III CM**
Movement	Indications for movement to a less intensive level of CM are: sustained increased level of functioning; increased independence. Decrease in symptoms, crisis episodes, and hospitalizations. Increased satisfaction with life domains.	**Movement to Level III CM:** Client can largely self-manage remaining objectives in Service Plan. Significant decrease in hospitalizations, and/or no crisis episodes, or client chooses a less involved level of CM. **Movement to Level I CM:** Increase in symptoms, increase in hospitalizations or crisis episodes, major life event or trauma requiring prolonged increased support.	**Movement to Level II CM:** Client is currently satisfied with life domains, but seeking a more goal oriented recovery process. Noticeable increase in symptoms or decrease in ability to manage symptoms and deficits. **Movement to Level I CM:** Significant increase in hospitalizations and crisis episodes, initiation or return to substance abuse, significant exacerbation of symptoms. **Termination of CM Services:** Client choice; significant degree of independence and self-management, strong positive family or significant other involvement, respecting the interests and choice of the family.

APPENDIX I

THE UTAH SCALE ON THE SERIOUSLY AND PERSISTENTLY MENTALLY ILL (SPMI)

(FOR USE WITH ADULTS)

DIMENSION I – SEVERITY: Mental health clients must meet three or more (check all that apply):

( ) A. **MEDICATION:** Receives psychoactive medication as part of treatment.

( ) B. **DIAGNOSIS/PROBLEM:** Diagnosis between 295 and 316, inclusively, or a problem of abuse victim syndrome.

( ) C. **INAPPROPRIATE DEPENDENCY:** on other for any three of the following: (1) food purchase and preparation, (20) personal hygiene, (3) transportation, (4) financial management, (5) living arrangement, and (6) leisure management.

( ) D. **PRODUCTIVITY PROBLEM:** Is either (1) marginally employed and would be unable to be employed without mental health services, (2) employed in a sheltered setting, (3) unemployable, or (4) receives specialized school or other services (if under age 16).

( ) E. **SOCIAL ISOLATION:** Is socially isolated, without friends and social support systems. Uses mental health system for social exchange. Includes severe isolation in school (if under age 16).

( ) F. **PUBLIC ASSISTANCE:** Receives public assistance to meet basic needs (Applies only to adult patients).

( ) G. **SYMPTOM REMISSION:** Symptoms are in remission, but the patient's condition would seriously deteriorate without continued mental health treatment and support.

( ) H. **ANTI-SOCIAL BEHAVIOR:** Has pattern of serious anti-social, criminal or delinquent acts.

DIMENSION II – PERSISTENCE: Must meet one of the following (please check):

( ) I. **MORE INTENSE TREATMENT:** History of a continuous episode of treatment more intensive than outpatient for two years or more.

( ) J. **OUTPATIENT TREATMENT:** History of a continuous episode of treatment in outpatient services for three years or more.

( ) K. **NO HISTORY:** Would meet above criterion I or J if service history was available or has met the severity criteria for three years or more without service.

( ) L. **RESISTIVE TO TREATMENT:** Is resistive to treatment and would meet criterion I or J had the patient not terminated for service against advice. Includes mental health-focused schooling (if under age 16).

( ) M. **PROSPECTIVE PERSISTENCE:** Extremely like to meet criterion I or J by subsequent continuous service or is expected to meet the severity criteria for three years or more.

( ) Yes ( ) No Check yes if three criteria are met in Dimension I and at least one criterion is met in Dimension II (Yes = SPMI/No = Non SPMI). (NOTE: Assessment must sufficiently document the items checked.)

Date:_____ Therapist Signature:_____